

To:

Date:

Dear

RE:

DOB:

Please find below an Eating Disorder Care Plan (EDP) prepared for this patient with details of their condition. This referral cover sessions 1-10 for psychological intervention, 1-20 for a dietitian, after which I will review and provide ongoing referrals as appropriate. Many thanks for your care and for your ongoing collaboration and communication.

Yours sincerely,

Name:

Date:

GP EATING DISORDER PLAN (EDP)

Item No: 90250 – 90257

[MBS Quick reference guide](#)

GP DETAILS			
GP Name		Practice Name & address	
Provider No.			
Practice phone		Practice fax	
GP Health Identifier			
GP Email			

PATIENT DETAILS			
First Name (as on Medicare)		Last Name	
Preferred Name		Marital Status	
Date of Birth		Age	
Gender Identity	As identified in software: Current identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary/Gender fluid <input type="checkbox"/> Different identity		
Address			
Phone (h)		Phone (m)	
Cultural Identity		Aboriginal or Torres Strait Islander	<input type="checkbox"/> Yes <input type="checkbox"/> No
First Language	Interpreter needed? <input type="checkbox"/> Yes		
Family/ support person details (Consider involving support person in session if appropriate) InsideOut resources for carers Butterfly resources for carers NEDC resources for carers	Preferred support person: _____ Ph: _____ Pt consent to contact given <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship to patient: <input type="checkbox"/> Very well supported <input type="checkbox"/> Well supported <input type="checkbox"/> Somewhat supported <input type="checkbox"/> Not supported Any information not to be shared with support person:		

Relevant Current Medications	
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ESTABLISH ACCESS TO EDP (If not appropriate consider using a MHCP or GPMP)	
Eating Disorder Diagnosis (DSM-V) InsideOut GP Hub – diagnostic guidelines	<input type="checkbox"/> Anorexia Nervosa (AN) (<i>Meets criteria for EDP</i>) <input type="checkbox"/> Bulimia Nervosa (BN) (<i>Other criteria needed, see below</i>) <input type="checkbox"/> Binge Eating Disorder (BED) (<i>Other criteria needed, see below</i>) <input type="checkbox"/> Other Specified Eating or Feeding Disorder (OSFED)(<i>Other criteria needed</i>)
EDE-Q Global Score InsideOut - EDE-Q online with scoring	EDE-Q Score (greater than or equal to 3 to access EDP for BN, BED or OSFED)
Eating Disorder Behaviours (At least one needed to access EDP and rebates for BN, BED or OSFED)	Eating disorder behaviours: <input type="checkbox"/> Rapid weight loss <input type="checkbox"/> Binge eating (<i>frequency >=3 times per week</i>) <input type="checkbox"/> Compensatory Behaviour (<i>frequency >=3 times per week</i>) <input type="checkbox"/> N/A (For AN) +Compensatory behaviours: <input type="checkbox"/> Purging <input type="checkbox"/> Excessive exercise <input type="checkbox"/> Laxative abuse <input type="checkbox"/> N/A Frequency of behaviour: <input type="checkbox"/> N/A <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Clinical Indicators (at least 2 to access EDP and rebates for BN, BED or OSFED)	Clinical Indicators: <input type="checkbox"/> Clinically underweight (<i>less than 85% expected weight with weight loss due to an ED</i>) <input type="checkbox"/> Current or high risk of medical complications due to ED <input type="checkbox"/> Serious comorbid psychological/medical conditions impacting function <input type="checkbox"/> Hospital admission for an ED in past 12mths <input type="checkbox"/> Suboptimal response to evidence-based treatment over past 6mths <input type="checkbox"/> N/A (For AN) Add detail as appropriate:
Access To EDP Established	<input type="checkbox"/> Yes <input type="checkbox"/> No (consider Better Access to Mental Health Plans)

MENTAL HEALTH ASSESSMENT & HISTORY	
Previous Specialist Mental Health Care	
Social & Family History	
Personal History <i>Childhood, education, relationship history, previous stressors, protective factors</i>	
Results of Mental State Examination Detail findings Royal Children's Hospital Melbourne Mental State Examination Guide	Appearance: General behaviour: Speech: Mood: Affect: Thought: Perceptions: Cognition: Insight:

Risk assessment Note any identified risks, including risks of self-harm Black Dog Institute resources	Identified risk <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Suicidal intent <input type="checkbox"/> Current plan <input type="checkbox"/> Risk to others <input type="checkbox"/> Medical risk <input type="checkbox"/> None Other:
	Plan for managing risk <input type="checkbox"/> Mental Health Line <input type="checkbox"/> After hours GP service <input type="checkbox"/> Family monitoring <input type="checkbox"/> GP monitoring Other:

MEDICAL REVIEW

Examination As indicated	Physical examination done: <input type="checkbox"/> N/A <input type="checkbox"/> Height, weight, BMI(adults) BMI percentile (children) <input type="checkbox"/> Pulse & blood pressure, with postural measurements <input type="checkbox"/> Temperature <input type="checkbox"/> Assessment of breathing & breath (e.g. ketosis) <input type="checkbox"/> Examination of periphery for circulation and oedema <input type="checkbox"/> Assessment of skin colour (e.g. anaemia, hypercarotenaemia, cyanosis) <input type="checkbox"/> Hydration state (e.g. moisture of mucosal membranes, tissue turgor) <input type="checkbox"/> Examination of head & neck (e.g. parotid swelling, dental enamel erosion, gingivitis, conjunctival injection) <input type="checkbox"/> Examination of skin, hair and nails (e.g. dry skin, brittle nails, lanugo, dorsal finger callouses (Russell's sign)) <input type="checkbox"/> Sit up or squat test (i.e. test of muscle power) Investigations done: <input type="checkbox"/> FBC <input type="checkbox"/> EUC/LFT/CMP/BSL <input type="checkbox"/> Urinalysis <input type="checkbox"/> Electrocardiography <input type="checkbox"/> Iron studies, B12, folate <input type="checkbox"/> E/P, LH/FSH, if appropriate TSH/PrI <input type="checkbox"/> Bone densitometry – <i>relevant after 9-12mths of disease or of amenorrhoea & as a baseline in adolescents. (Recommendation is for 2yrly scans thereafter while DEXA scans are abnormal)</i>
Observations: Medical complications: Psychological/ medical comorbidities: Protective factors: Emergency care/relapse prevention:	

INITIAL TREATMENT RECOMMENDATIONS UNDER EDP		
Psychological treatment services (EDPT) (Initial 10 sessions)	Dietetic services (up to 20 in 12 months) <i>Dietitian to provide letter of treatment to GP on completion</i>	Psychiatric/paediatric review <i>Assessment by psychiatrist/ paediatrician required for patient to access EDPT sessions 21-40</i>
Referred to: Phone: Goals: Psychological treatments allowed under EDP (to be determined together with MH professional): <ul style="list-style-type: none"> Family based treatment, Adolescent focused therapy, CBT, CBT-AN, CBT-E, SSCM for AN, MANTRA for AN, IPT for BN or BED, DBT for BN or BED, Focal psychodynamic therapy for EDs 	Referred to: Phone: Goals: BBDiet Dietitian Services (Angeline Stania) 07-3067 7280 / 0433 912 208 admin@bbdiet.com.au InsideOut Treatment Services Database	Referred to: Phone: Other team member Profession: Name: Phone:
GP management – frequency of review <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> As indicated Actions for patient to take: <input type="checkbox"/> Use of the Healthy Mind Platter <input type="checkbox"/> Read through RAVES Approach <input type="checkbox"/> Build my treatment team <input type="checkbox"/> Engage Family/Friends <input type="checkbox"/> Limit my exercise to set amount <input type="checkbox"/> Attend all appointments with dietitian/psychologist <input type="checkbox"/> Use Plate by Plate Other actions identified by patient: Patient education given <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: Copy of EDP offered to patient <input type="checkbox"/> Yes <input type="checkbox"/> No		

GP REVIEW REQUIREMENTS
Mental health: Prior or at sessions 10, 20 & 30 of psychological treatment & at EDP completion Dietetics: At EDP completion Note: PSYCHIATRIC OR PAEDIATRIC REVIEW Required in addition to GP review to access sessions 21-40. <i>Consider referring early in course of treatment.</i>

RECORD OF PATIENT CONSENT
I, _____ (patient name - please print clearly) Agree to information about my mental and medical health to be shared between the GP and the health professionals to whom I am referred, and to participate in case conferences to assist in the management of my health care. Signature (patient): _____ Date: _____ I (GP) have discussed the proposed referral(s) with the patient and am satisfied that the patient understands the proposed uses and disclosures and has provided their informed consent to these. GP Signature _____ GP Name _____ Date _____